



Companion Guide for

Blue Cross Blue Shield of Massachusetts



**Version 2.3h
NPI**

**X12N 835 (Version 004010X091A1)
Health Care Claim Payment/Advice**

Implementation Guide & Addenda

Table of Contents

Introduction.....	3
Establishing Connectivity with BCBSMA.....	4
Contact Names.....	4
Communication Software Recommendations.....	4
Setting up Your Connection.....	5
Frame Relay.....	5
Dial-Up Networking.....	5
What You Will Need.....	5
Dial-Up Networking Connection Set-Up (95/98).....	6
Installing Drivers.....	6
Configuration.....	7
Dial-Up Networking Connection Set-Up (XP).....	8
Dial-Up Networking Connection Set-Up (2000).....	11
Testing.....	14
Remittance Retrieval Steps.....	15
Retrieving Remittance Files.....	15
Retrieving Remittance Reports.....	16
FTP Remittance Command Quick Reference Table.....	16
Reporting/File.....	17
ANSI 835 Electronic Remittance File (RMTFIL:X12_835).....	17
ANSI 835 Remittance Report (RMTRPT:X12_835).....	17
BCBSMA Specific 835 Comments/Instructions.....	18
Appendix A.....	20
BCBSMA Message Code Mappings.....	20

The content in this guide will be revised and republished when Emdeon Business Services makes improvements and/or changes to any referenced product, process for program. This documentation is the confidential and proprietary property of Emdeon Business Services. Any unauthorized use; reproduction or transfer of the documentation is strictly prohibited.

©2006, 2007, 2008 Emdeon Business Services. All Rights Reserved. Printed in the USA.

Version 2.3h Last Edited: 04/24/2008

Blue Cross and Blue Shield of Massachusetts, Inc., is an Independent Licensee of the Blue Cross and Blue Shield Association.
®Registered Marks of the Blue Cross and Blue Shield Association.

Introduction

What is HIPAA?

The Health Insurance Portability and Accountability Act - Administration Simplification (HIPAA-AS) requires that Blue Cross Blue Shield of Massachusetts (BCBSMA), Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services. The X12N 835 version 4010 implementation guide for Health Care Claim Payment/Advice and the Addenda (A1) have been established as the standard for electronic remittance transaction compliance.

Purpose of the Implementation Guide

The Health Care Claim Payment/Advice (X12N 835 version 4010) implementation guide and the Addenda (A1) are designed to assist those who send and/or receive Electronic Remittance Advice (ERA) and/or payments in the 835 format. As a remittance advice, the 835 provides detailed payment information relative to a health care claim(s) and, if applicable, describes why the total original charges have not been paid in full. This remittance information is provided as "justification" for the payment, as well as input to the payee's patient accounting system/accounts receivable (A/R) and general ledger applications. The 835 is also used to convey information about provider offsets (hospital settlements, tax levy, etc.) and will reference the accounts receivable number that has been established. Although the implementation guide contains requirements for use of specific segments and data elements within the segments, the guide was written for use by all health benefit payers.

Purpose of the Companion Guide

This document has been prepared as a *Blue Cross Blue Shield of Massachusetts* specific companion document to that implementation guide. This companion guide document *supplements*, but does not contradict any requirements in the 835 version 4010 implementation guide or the Addenda. Providers who receive 835 transactions *and* who submit *paper* claims may notice that some of the required fields contain 'zeroes' or 'unknown' if the information was not available or provided on the paper claim forms.

How to obtain copies of the Implementation Guides

The implementation guides for all HIPAA transactions are available electronically at the Washington Publishing Company (WPC) website at www.wpc-edi.com/HIPAA. The Adjustment Reason Codes for the remittance can be found at http://www.wpc-edi.com/ClaimAdjustment_40.asp. and Remittance Remark Codes can be found at http://www.wpc-edi.com/Remittance_40.asp.

Intended Audience

The intended audience for this document is the technical area that is responsible for receiving electronic 835 transactions from *Blue Cross Blue Shield of Massachusetts*. In addition, this information should be communicated and coordinated with the provider's billing office.

Paper Provider Detail Advisory (PDA) Notices

Paper PDA's will not change; they will continue to reflect values used internally by BCBSMA, not the values in the 835 transaction.

Establishing Connectivity with BCBSMA

The purpose of this section is to identify the process for establishing connectivity to transmit electronic transactions to Blue Cross Blue Shield of Massachusetts.

Contact Names

Type of Contact	Area Contact	Telephone Number	Email Address
Technical	Emdeon	1-800-266-2206 option 6, then option 2	
Business	BCBSMA	Provider Representative	hipaa.regulations@bcbsma.com

Communication Software Recommendations

The following table outlines the options for connection to the BCBSMA system.

If you wish to access HealthWire-Direct via:	You will need:	You can use these protocols:
TCP/IP (Frame-relay) <i>This type of connection is recommended for those submitting large volumes of claims</i>	<ul style="list-style-type: none"> • Circuit • CSU/DSU • Router • Commercially available communications package which supports TCP/IP 	File Transfer Protocol (FTP)
TCP/IP (Dial-Up networking using Point-to-Point Protocol)	<ul style="list-style-type: none"> • 56K/V.90 Modem • Dial-Up Networking support enable within Windows (95/98/ME/NT/2000 or XP) • TCP/IP Protocol 	File Transfer Protocol (FTP)

Setting up your Connection

Frame Relay

Before determining whether a Frame Relay connection should be utilized or established for HealthWire Direct submissions contact Emdeon to discuss your organizations current set up and needs.

1. **Contact Emdeon** (see the **Contact Names** section of this guide) to establish your personal Emdeon Contact. Your Emdeon Contact will work directly with you throughout the connection implementation process.
2. **Contact your telecommunications carrier.** The telecommunications carrier will need to contact Emdeon for authorization to establish the connection.
3. Once the connection has been authorized you will need to **install a frame-relay circuit, TCP/IP and any associated equipment** (i.e. CSU/DSU, TCP/IP, Router, etc.).
4. Your Emdeon Contact will provide you with a **login ID** and **password**, and work with you to successfully complete the necessary data communications work required to **successfully “ping” the Emdeon system.**

Dial-Up Networking

The following sections outline the steps to install Dial-Up Networking on a Windows 95/98/2000 and XP systems. These are general instructions, and while they should work most of the time, they might not work in all circumstances.

1. **Contact Emdeon** (see the **Contact Names** section of this guide) to establish your personal Emdeon Contact. Your Emdeon Contact will work directly with you throughout the connection implementation process.

What you will Need

Here is a list of what you will need before you can use Dial-Up Networking to connect with HealthWire-Direct.

- The **phone number** supplied by your Emdeon Contact.
- Your **username** and **password** supplied by your Emdeon Contact.
- Any Windows-compatible **modem** of at least 14,400 baud, installed and functioning.

Dial-Up Networking Connection Set-Up (95/98)

Installing Drivers

The following describes the process for installing the proper drivers. Take the following steps to insure you have the proper drivers installed:

1. From the Control Panel, double click on the **Add/Remove Programs** icon.
2. From the Add/Remove Programs window click the **Windows Setup** tab, highlight **Communications** in the list of components, and click **Details**.
3. Make sure you have a check mark next to the **Dial-Up Networking component**. If not, check it now, and click **OK**; you will be asked to restart your computer at this point.
4. From the Control Panel, select the **Network** icon. You will need the following network components installed:
 - Client for Microsoft Networks
 - Dial-Up Adapter
 - TCP/IP
5. If these items are not currently installed, click **Add** to add them to your list.

Note: Client for Microsoft Networks is a “client”, Dial-Up Adapter is an “adapter” and TCP/IP is a “protocol”. All of these components can be found by selecting Microsoft in the Manufacturers list for that specific component type.

6. If you have other adapters installed, such as a network card, make sure TCP/IP is installed for the dial-up adapter as well as the network card.
7. If you made any changes you will have to restart Windows.

Dial-Up Networking Connection Set-Up (95/98)- continued

Configuration

Once you've obtained the necessary information and have installed the correct drivers, you can configure Dial-Up Networking to work with the HealthWire-Direct network.

1. From **My Computer** double-click **Dial-Up Networking**
2. **Double-click Make New Connection**, if you don't already have one.

Enter a name for this connection (we suggest HealthWire or Emdeon) and select the modem you will be using from the list.

3. Click **configure** to make sure the modem is configured correctly.

Set the maximum speed to 57,600 for 14.4 modems and 115,200 for 28.8 or faster modems. You might want to turn up the volume until you're sure the connection works.

4. Click **Next** and then type in the phone number supplied by your Emdeon contact. Make sure **Only connect at this speed** is NOT checked and click **OK**.
5. Click **Next** and then **Finish**.
6. Right-click on your new connection icon and select **Properties**.
7. From the tabs at the top choose the **Server Types** tab and turn off all options on that panel except for **Enable software compression** and **TCP/IP**.
8. Click **TCP/IP Settings**, verify that Server assigned IP address and Server assigned name server addresses are selected. If not, select them. Make sure **Use IP header compression** and **Use default gateway on remote network** are both checked.
9. Click **OK** and **OK** again.
10. Double-click on the connection icon to connect!

You can drag the new connection icon to your desktop for easy access.

Dial-Up Networking Connection Set-Up (XP)

Configuration

Once you've obtained the necessary information and have installed the correct drivers, you can configure Dial-Up Networking to work with the HealthWire-Direct network.

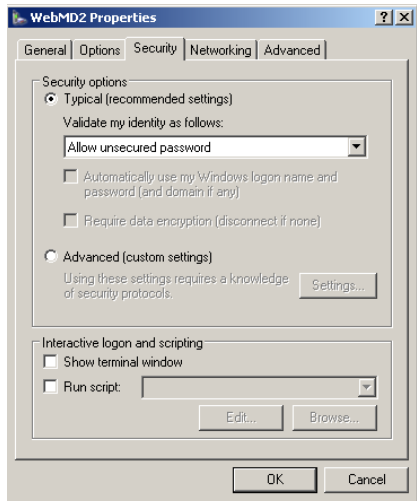
1. From the Control Panel select the **Network Connections** icon. On the left side of the screen under **Network Tasks**, select **Create a new connection**.
2. On the **Welcome to the New Connection Wizard** screen click **Next**.
3. Under **Network Connection Type** click on the **Connect to the network at my workplace** radio button and click **Next**.
4. Verify that the Dial-up connection radio button is checked and click **Next**.
5. Enter the name for this connection (we suggest HealthWire or Emdeon) and click **Next**.
6. Type in the phone number supplied by your Emdeon contact and click **Next**.
7. On the **Completing the New Connection Wizard** click **Finish**.
8. The following connection screen will appear. Click on the **Properties** button.



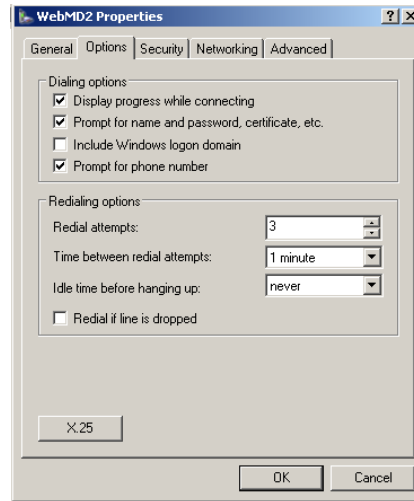
Dial-Up Networking (XP)- continued

9. Please make sure that the settings are as they appear in the following screenshots.

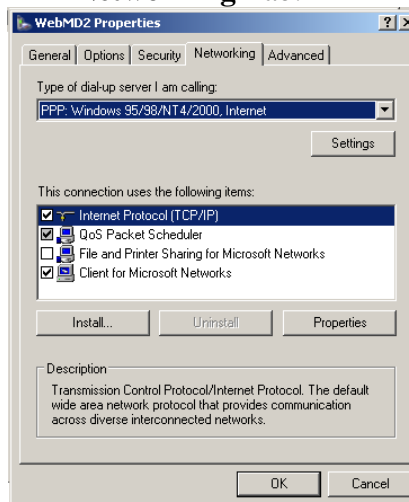
Options Tab:



Security Tab:



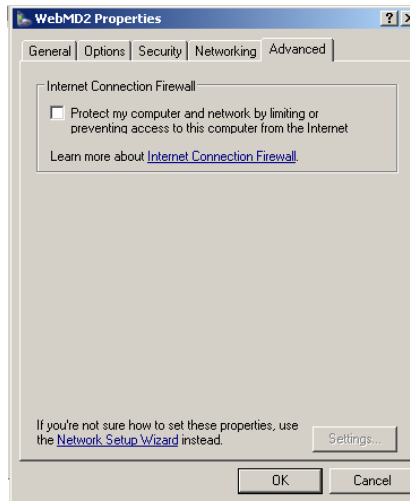
Networking Tab:



Verify that Internet Protocol (TCP/IP) and Client for Microsoft Networks are installed.

Dial-Up Networking Connection Set-Up (XP)- continued

Advanced Tab:



10. After verifying the connection properties Click **Ok** and then **Cancel**.

11. Double-click on the connection icon to connect. Type in your username and password and Click **Dial**.

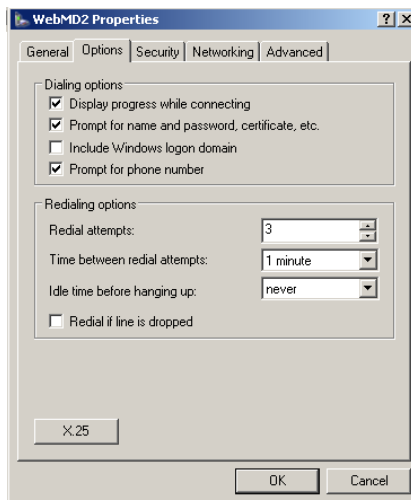
Dial-Up Networking Connection Set-Up (2000)

Configuration

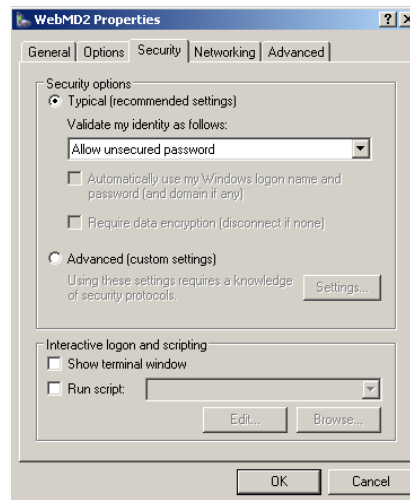
Once you've obtained the necessary information and have installed the correct drivers, you can configure Dial-Up Networking to work with the HealthWire-Direct network.

1. From the Control Panel select the **Network and Dial-up Connections** icon and Click on **Make New Connection**.
2. On the **Welcome to the New Connection Wizard** screen click **Next**.
3. Under **Network Connection Type** click on the **Dial-up to private network** radio button and click **Next**.
4. Type in the phone number supplied by your Emdeon contact and click **Next**.
5. Verify that the **For all users** radio button is checked under **Connection availability** and click **Next**.
6. Enter the name for this connection (we suggest HealthWire or Emdeon) and click **Finish**.
7. Double-click on the connection icon and Click **Properties**.
8. Please insure that the settings are as they appear in the following screenshots.

Options Tab:

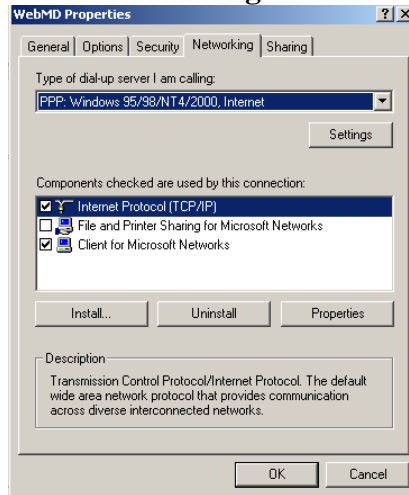


Security Tab:



Dial-Up Networking Connection Set-Up (2000)- continued

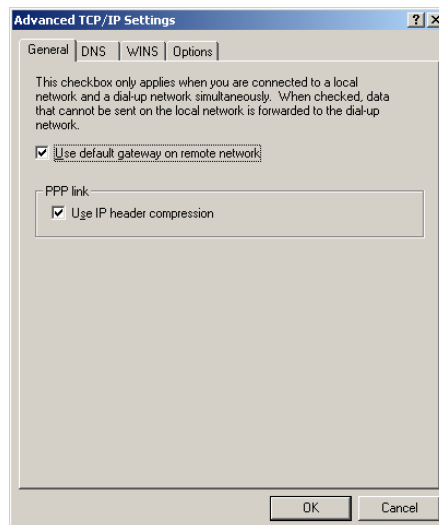
Networking Tab:



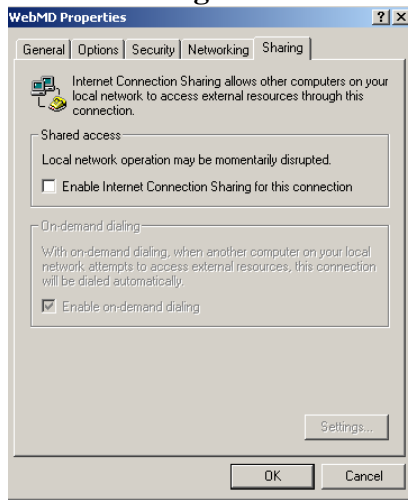
Verify that Internet Protocol (TCP/IP) and Client for Microsoft Networks are installed.

9. Select **Internet Protocol (TCP/IP)** and select **Properties**. From the **Internet Protocol (TCP/IP) Properties General** tab select **Advanced**. The Advanced TCP/IP Setting window will appear. Please insure that the settings are as they appear in the following screenshot.

Advanced TCP/IP Settings:



Sharing Tab:



10. After verifying the connection properties Click **Ok**.

11. Type in your username and password and Click **Dial**.

Testing

Emdeon clients who wish to begin the testing process for the receipt of ANSI 835 (4010-A1) Electronic Remittances must notify Emdeon to have their account flagged (please see the *Contact Names* section of this guide). To receive your 4010-A1 remittance file follow the steps as outlined on the following page.

Note: Electronic transactions that follow these protocols will be transmitted via secure communication channels.

Remittance Retrieval Steps

Retrieving Remittance Files

To receive a remittance file, follow these steps:

1. Open a DOS prompt.
2. Enter the IP address to the production region.
3. Sign-on to the HealthWire-Direct production region using the login and password assigned.
4. Type **binary** and hit Enter.
5. Type the FTP receive command as:

get SUBMITTER ID!HREMIT (drive):\ (local file name)

**example: get 91852!HREMIT c:\remit020103.fil*

Local file name *is the name and directory for storing the file on your system*

SUBMITTER ID *is the Submitter ID assigned by Emdeon.*

6. Continue the “**get**” command until you do not receive any more output files.
7. Type “**quit**” or “**bye**” to log off the HealthWire Direct system.

Retrieving Remittance Reports

To receive a remittance report, follow these steps:

1. Open a DOS prompt.
2. Enter the IP address to the production region.
3. Sign-on to the HealthWire-Direct production region using the login and password assigned.
4. Type **ascii** and hit Enter.
5. Type the FTP receive command as:

get SUBMITTER ID!HRMRPT (drive):\ (local file name)
 *example: get 91852!HRMRPT c:\remit020103.rpt

Local file name is the name and directory for storing the report on your system

SUBMITTER ID is the Submitter ID assigned by Emdeon.

6. Continue the “**get**” command until you do not receive any more report files.
7. Type “**quit**” or “**bye**” to log off the HealthWire Direct system.

FTP Remittance Command Quick Reference Table

Code	Description	FTP Command
HREMIT:X12_835	ANSI 835 (4010-A1) Electronic Remittance File	get SUBMITTER ID!HREMIT (drive):\ (local file name)
HRMRPT:X12_835	ANSI 835 (4010-A1) Remittance Report	get SUBMITTER ID!HRMRPT (drive):\ (local file name)
OREMIT:X12_835	ANSI 835 (4010-A1) Electronic Remittance File (Out of Balance)	get SUBMITTER ID!OREMIT (drive):\ (local file name)
ORMRPT:X12_835	ANSI 835 (4010-A1) Remittance Report (Out of Balance)	get SUBMITTER ID!ORMRPT (drive):\ (local file name)

Reporting/File

This section will identify and describe the Payment/Advice reports issued by Blue Cross Blue Shield of Massachusetts. All files and reports are available for seven days after they are posted on the system. It is important to check the system periodically throughout the week as file(s) may be have become available.

Report/File Number	Report/File Name	Source
HREMIT:X12_835	ANSI 835 Electronic Remittance File	Mailbox
HRMRPT:X12_835	ANSI 835 Remittance Report	Mailbox
OREMIT:X12_835	ANSI 835 Electronic Remittance File (Out of Balance)	Mailbox
ORMRPT:X12_835	ANSI 835 Remittance Report (Out of Balance)	Mailbox

ANSI 835 Electronic Remittance File (HREMIT:X12_835)

The ANSI 835 Payment/Advice indicates the outcome of claims after they are processed by Blue Cross Blue Shield of Massachusetts. It includes the claim number, a summary of the services submitted, and the provider number. If a claim was paid, the file will include the paid amount, check number, deductible or co-pay amount if applicable and whether or not there is a patient balance. If a claim was not paid in full, the file will include the standard adjustment reason codes for the amount not paid.

ANSI 835 Remittance Report (HRMRPT:X12_835)

The report accompanies the electronic remittance file. This report contains a brief summarization of the data contained in the remittance file.

ANSI 835 Electronic Remittance File – Out of Balance (OREMIT:X12_835)

This file, when present, contains only those ERAs that are out of balance (do not pass HIPAA level 3 validation).

ANSI 835 Remittance Report – Out of Balance (ORMRPT:X12_835)

The report accompanies the “out of balance “electronic remittance file. This report contains a brief summarization of the data contained in the remittance file.

BCBSMA Specific 835 Comments/Instructions

General

The purpose of this section is for payers to provide comments or instructions to providers or their billing agents for certain data elements and segments on the 835 Payment/Advice.

835 Guide Data Implementation				
Position	Segment ID / Data Element Number	Description	835 Requirements	Blue Cross Blue Shield of MA Comments
GS – FUNCTIONAL GROUP HEADER				
	GS	Functional Group Header	To indicate the beginning of a functional group and to provider control information.	
	GS08 / 480	Version / Release / Industry Code	Required.	This field will reflect value: 004010X091A1 (Addenda version).
Loop REASSOCIATION TRACE NUMBER				
040	TRN	Trace	The TRN segment is used to uniquely identify a claim payment and advice.	
040	TRN02 / 127	Reference Identification	Required. This is the check or EFT Trace Number assigned by the sender.	In lieu of an actual check number, BCBSMA will indicate ' Encounter ' for claim encounters or ' Pretreat ' for pre-treatment estimates for dental claims.
Loop 1000B Payee Identification – Billing Provider				
080	N103 / 66	Identification Code Qualifier	Required Field Values <u>XX</u> for NPI <u>FI</u> for Tax ID	Billing Provider Information If a billing provider has an NPI then the Identification Code Qualifier will be populated with ' <u>XX</u> '. If a billing provider is considered atypical (<u>not</u> eligible to obtain an NPI) then the Identification Code Qualifier will be populated with ' <u>FI</u> '.
080	N104 / 67	Identification Code	Required Field Values NPI or Tax ID	Billing Provider Information If the Identification Code Qualifier (N103) is ' <u>XX</u> ' then the Identification Code will be populated with the billing provider's 10-digit NPI. If the Identification Code Qualifier (N103) is ' <u>FI</u> ' then the Identification Code will be populated with the billing provider's Tax ID.

BCBSMA Specific 835 Comments/Instructions (continued)

835 Guide Data Implementation				
Position	Segment ID / Data Element Number	Description	835 Requirements	Blue Cross Blue Shield of MA Comments
Loop 1000B Payee Identification – Billing Provider TAX ID#				
120	REF01/128	Reference Identification Qualifier	Required Field Values <u>TJ</u> for Tax ID <u>PQ</u> for Legacy ID	Billing Provider Information If the Identification Code (N104) is populated with an NPI then the Reference Identification Qualifier will be coded with 'TJ' to indicate the billing provider's Tax ID. If the billing provider is considered atypical (not eligible to obtain an NPI) then the Reference Identification Qualifier will be coded with 'PQ' to indicate the billing provider's Legacy ID.
120	REF02/127	Reference Identification	Required Field Value Tax ID or Legacy ID	Billing Provider Information If the Reference Identification Qualifier (REF01) is ' <u>TJ</u> ' then the Reference Identification Code will be populated with the billing provider's Tax ID. If the Reference Identification Qualifier (REF01) is ' <u>PQ</u> ' then the Reference Identification Code will be populated with the billing provider's Legacy ID.
Loop 2100 CLAIM PAYMENT INFORMATION				
010	CLP	Claim Level Data	To supply information common to all services of a claim.	
010	CLP06/1032	Claim Filing Indicator	Required. The code identifying the type of claim. This value should mirror the value received in the original claim (2-005 SBR09 of the 837), if applicable, or provide the value as assigned or edited by the payer.	According to the 835 Implementation Guide, BL is not a valid value for this field. Therefore, if you submitted a value of BL (Blue Cross Blue Shield) in the SBR09 field of the 837, we will <i>default</i> to a value of 12 (Preferred Provider Organization - used for BCBS par arrangements) in this field on the 835.
010	CLP07/127	Reference ID	This must be provided whenever the payer assigns an internal claim number and desires this reference from the provider as a part of any customer service contact or appeal process.	Please refer to this payer assigned claim number when making an inquiry or appeal on this claim to BCBSMA.

BCBSMA Specific 835 Comments/Instructions (continued)

835 Guide Data Implementation				
Position	Segment ID / Data Element Number	Description	835 Requirements	Blue Cross Blue Shield of MA Comments
Loop 2110 CLAIM ADJUSTMENT				
020	CAS	Claims Adjustment	To supply adjustment reason code and amounts as needed for an entire claim or for a particular service within the claim being paid.	
020	CAS01-CAS19 / 1033, 1034, 782, 380	Claims Adjustment	Situational. Payers must use this CAS segment to report claim level adjustments that cause the amount paid to differ from the amount originally charged.	This claim level segment is not applicable to BCBSMA business. The claims adjustment information is reported within the line level segments and not the header segment.
Loop 2100 CORRECTED PATIENT / INSURED NAME				
030	NM1	Individual or Organizational Name	To supply the full name of an individual or organizational entity.	
030	NM103 / 1035	Name Last	Required when <i>corrected</i> LAST NAME for the insured is available.	The LAST NAME reflects the information contained in our membership records. If this information is different than what you submitted, you may need to update your records for future claim submissions.
030	NM104 / 1936	Name First	Required when <i>corrected</i> FIRST NAME for the insured is available.	The FIRST NAME reflects the information contained in our membership records. If this information is different than what you submitted, you may need to update your records for future claim submissions.

BCBSMA Specific 835 Comments/Instructions (continued)

835 Guide Data Implementation				
Position	Segment ID / Data Element Number	Description	835 Requirements	Blue Cross Blue Shield of MA Comments
030	NM105 / 1037	Name Middle	Required when <i>corrected</i> MIDDLE NAME for the insured is available.	The MIDDLE NAME reflects the middle initial contained in our membership records. If this information is different than what you submitted, you may need to update your records for future claim submissions.
030	NM107 / 1039	Name Suffix	Required when <i>corrected</i> SUFFIX for the insured is available.	If the patient is listed on our membership files with a suffix, it will be included as part of the last name.
030	NM109 / 67	Identification Code	Required when <i>corrected</i> IDENTIFICATION CODE the insured is available.	The IDENTIFICATION CODE reflects the Certificate Number/Subscriber Identification Number contained in our membership records. If this number is different than what you submitted, you may need to update your records for future claim submissions.
Loop	2110	SERVICE PAYMENT INFORMATION		
070	SVC	Service Information	To supply payment and control information to a provider for a particular service.	
070	SVC05 / 380	Quantity	This is required when the paid units of service provided in SVC05 are different from the submitted units of service from the original claim. This is not used when the submitted units are the same as the value in SVC05.	BCBSMA will populate this field for anesthesia services since the claims adjudication system converts time information submitted on the claim to units for internal claims processing.
070	SVC06 / C003	Composite Medical Procedure Code	This is required when the adjudicated procedure code provided in SVC01 is different from the submitted procedure code from the original claim. This is not used when the submitted code is the same as the code on SVC01.	If the procedure code in this field is different than the one reported in the SVC01 segment, the value was changed during the claims adjudication process.
Loop	2110	SERVICE ADJUSTMENT		
090	CAS	Claims Adjustment	To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid.	
090	CAS01 / 1033	Claim Adjustment Group Code	Required. Code identifying the general category of payment adjustment. Valid values are: PR: Patient Responsibility CO: Contractual Obligations PI: Payer Initiated Reductions CR: Correction and Reversals OA: Other Adjustments	PR: The amount adjusted in this field is the patient's responsibility. CO: The amount adjusted in this field is not the patient's responsibility under any circumstances due to either a contractual obligation between the provider and the payer or a regulatory requirement. PI: The amount in this field is not the responsibility of the patient. CR: This claim is a reversal of a previous payment. Claim Status Code (CLP02) = 22. OA: This will be used when no other category is appropriate. Refer to Adjustment Reason Code/Remark Code fields.

BCBSMA Specific 835 Comments/Instructions (continued)

835 Guide Data Implementation				
Position	Segment ID / Data Element Number	Description	835 Requirements	Blue Cross Blue Shield of MA Comments
Loop 2110 RENDERING PROVIDER INFORMATION				
100	REF	Reference Identification	To specify identifying information.	
100	REF01 / 128	Reference Identifier Qualifier	Required Field Values <u>HPI</u> for NPI <u>1A</u> for Legacy ID	Rendering Provider Information If a rendering provider has an NPI then the Reference Identifier Qualifier will be coded with ' <u>HPI</u> '. If a rendering provider is considered not eligible to obtain an NPI then the Reference Identifier Qualifier will be coded with ' <u>1A</u> '.
100	REF02 / 127	Reference Identification Code	Required Field Values NPI or Legacy ID	Rendering Provider Information If the Reference Identifier Qualifier (REF01) is ' <u>HPI</u> ' then the Reference Identification Code will be populated with the rendering provider's 10-digit NPI. If the Reference Identifier Qualifier (REF01) is ' <u>1A</u> ' then the Reference Identification Code will be populated with the rendering provider's Legacy ID.
PLB				
Provider Level Adjustment				
To convey provider level adjustment information for debit or credit transactions.				
010	PLB01 / 127	Reference Identification	Required Field Values Billing Provider NPI or Billing Provider Legacy ID	Billing Provider Information If the Billing Provider Identification Code (Loop 1000B - N104) is populated with an NPI then the PLB Reference Identification will be coded with the billing provider's 10-digit NPI. If a billing provider is <u>not</u> eligible to obtain an NPI then the PLB Reference Identification will be coded with the billing provider's Legacy ID.

Appendix A

BCBSMA Message Code Mappings to HIPAA Adjustment Reason Codes / Group Codes

The purpose of this section is to list some common examples of the Adjustment Reason Codes and Claim Adjustment Group Codes that will be listed on the electronic 835 remittance for some of Message Codes assigned by BCBSMA. BCBSMA may, at any time, make changes to these mappings.

BCBSMA PDA Message Code	BCBSMA Brief Narrative	HIPAA Adjustment Reason Code and Description	HIPAA Claim Adjustment Group Code
B090	Claim was submitted beyond timely filing period.	29 - The time limit for filing has expired.	CO - Contractual obligation
B307	We cannot pay this claim because the member received these services without prior plan authorization.	38 - Services not provided or authorized by designated (network) providers.	PR - Patient Responsibility
E232	This service is not covered under the member's contract.	96 - Non-covered charge(s).	PR - Patient Responsibility
E287	According to our records, at the time the services were performed, the patient was not enrolled on this plan under the ID # submitted.	32 - Our records indicate that this dependent is not an eligible dependent as defined.	PR - Patient Responsibility
E240	Services after coverage cancellation date.	27 - Expenses incurred after coverage terminated.	PR - Patient Responsibility
E620	This routine service is not covered under the member's contract.	96 - Non-covered charge(s).	PR - Patient Responsibility
E624	This service is included in the overall care of the patient. There is no separate reimbursement. There is no patient balance.	97 - Payment is included in the allowance for another service/procedure.	PI - Payer Initiated Reductions
M105	These services are not covered under the member's contract.	96 - Non-covered charge(s).	PR - Patient Responsibility
U301	Duplicate claim.	18 - Duplicate claim/service.	PI - Payer Initiated Reductions
U302	Duplicate claim.	18 - Duplicate claim/service.	PI - Payer Initiated Reductions
U715	Payment for this procedure is included in the payment for a related procedure that you performed on the same date. There is no patient balance.	97 - Payment is included in the allowance for another service/procedure.	PI - Payer Initiated Reductions
X009	This service is not covered under the member's contract.	96 - Non-covered charge(s).	PR - Patient Responsibility
U723	We're including our payment for this service in the payment we're making to you for a related rebundled procedure. There is no patient balance.	97 - Payment is included in the allowance for another service/procedure.	PI - Payer Initiated Reductions
X118	The claim was submitted with the wrong ID.	31 - Claim denied as patient cannot be identified as our insured.	PR - Patient Responsibility